

# REQUEST TO PARTICIPATE IN POLICY PROPOSAL REVIEW

## Michigan Department of Community Health

Parties interested in receiving proposed changes to Department of Community Health administered programs (e.g. Medicaid, Children's Special Health Care Services, State Medical Program, Community Mental Health Services Programs, etc.) for comment should complete this form and submit it to the e-mail address noted below. Upon receipt of the request, the DCH will forward electronic copies of proposed changes related to the providers or issues designated on the request form.

### COMPLETION INSTRUCTIONS:

- Check the box for the general category OR the individual subcategories.
- To receive copies of all proposed changes, check the "ALL PROVIDER TYPES" category only.
- Complete the requestor information section at the bottom of the form.
- E-mail the request to [MSADraftPolicy@state.mi.us](mailto:MSADraftPolicy@state.mi.us)

<input type="checkbox"/> <b>ALL PROVIDER TYPES</b> <i>(do not check any other boxes)</i>	
<input type="checkbox"/> Ambulance	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Practitioners (includes physicians, advanced practice nurses, podiatrists, and medical clinics)
<input type="checkbox"/> Dental	<input type="checkbox"/> School Based Services
<input type="checkbox"/> Family Planning Clinics	<input type="checkbox"/> Vision
<input type="checkbox"/> Hearing & Speech Centers	<input type="checkbox"/> Community Mental Health Services Programs
<input type="checkbox"/> Hearing Aid Dealers	<input type="checkbox"/> Federally Qualified Health Centers
<input type="checkbox"/> Home Health	<input type="checkbox"/> Local Health Departments
<input type="checkbox"/> Hospice	<input type="checkbox"/> Medicaid Health Plans
<input type="checkbox"/> Hospitals	<input type="checkbox"/> Rural Health Clinics
<input type="checkbox"/> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Tribal Health Centers
<input type="checkbox"/> Independent Laboratories	<input type="checkbox"/> Children's Special Health Care Services
<input type="checkbox"/> Long Term Care	<input type="checkbox"/> MIChild
<input type="checkbox"/> Maternal & Infant Support Services	<input type="checkbox"/> Medical Programs Eligibility Manual
<input type="checkbox"/> Medical Suppliers / Durable Medical Equipment	
<input type="checkbox"/> Orthotics / Prosthetics	

### REQUESTOR INFORMATION

Name	
Agency or Association (if applicable)	
Mailing Address	
Telephone Number	E-Mail Address

**Authority:** Title XIX of the Social Security Act  
**Completion:** Is VOLUNTARY, but is required if Requested Actions are to be considered.

*The Michigan Department of Community Health is an equal opportunity employer, services, and program provider.*